Connecticut Community KidCare

STATUS REPORT

A
Quarterly Report Submitted to

THE CONNECTICUT GENERAL ASSEMBLY

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Purpose:

This document serves as the tenth quarterly report issued by the Department of Children and Families and Social Services regarding the status of the children's behavioral health program, Connecticut Community KidCare. As required by PA01-2, this document serves to update the General Assembly on the progress of this system reform.

Programmatic Update

This tenth quarterly report is issued after significant delay due to DCF's on-going efforts to enhance the manner in which data submitted by various service providers is analyzed. This report presents information reported on each of the defined service categories and to identify trends in the utilization of those service categories.

It is anticipated that once the Administrative Services Organization is fully operational, both DCF and DSS will have greater access to encounter data that is more thorough and detailed. Until DCF is able to access the data warehouse within the proposed ASO or develop and exercise an enhanced data collection protocol for children served using state funded KidCare resources, the contents within this report and others will be limited in detail.

Emergency Mobile Services:

The statewide network of children's mobile crisis teams continues to respond to urgent calls from a variety of sources seeking immediate assistance or consultation regarding a child's behavioral health concern. The sixteen emergency mobile crisis teams have answered almost 12, 630 calls since the program's inception in 2002.

During the second quarter on FY'05 (October 1, 2004 –December 30, 2004) there were **1398** calls made to the mobile crisis teams throughout the state. Services were provided to **715** boys and **683** girls. **1027** children referred for service (3/4) **had no DCF involvement,** while 371 (1/4) were involved with the Department. Almost half of the calls (758) were made on behalf of children ages 11 –15. This age group has consistently been the focus of the majority of the calls coming into the units. However, during this quarter, all age groups were represented in the utilization of mobile crisis services. 68 calls came in regarding children under the age of five, 309 calls were received regarding children between the ages of 6-10, and 261 calls were received regarding youth aged 16 and above.

Consistent with past trends, the majority of calls to Emergency Mobile crisis teams were made by parents or caregivers (461). As expected, calls from school personnel rose this quarter with school resuming after the summer break. A total of 379 calls were received from school staff. Hospital Emergency Departments made 53 calls and out-patient facilities made 136 calls to the crisis teams. The remaining calls came from a variety of sources including shelters, courts, social service agencies, DCF workers, and police officers. 19 children self referred.

Of the 1398 calls received, 400 required phone consultation only. 321 calls resulted in an emergency visit to the child's home, and 179 initial visits were held in school settings. An additional 104 visits were made to emergency departments to assist with discharge planning. 228 calls received follow-up in a clinic office and 110 callers were seen in one of the EMS offices. Visits to shelters, and "other " face to face encounters accounted for the remaining 58 calls.

Care Coordination:

Care Coordinators continue to provide assistance to families who need help to organize their child's treatment and identify/procure appropriate service. Since DCF began collecting data from Care Coordinators in January 2002, almost **1700** children have received this service. **Approximately 700** children received this service during this quarter (includes, discharges, admissions and carry forwards from previous quarter).

The 60 state-funded Care Coordinators work closely with the 26 existing Community Collaboratives (Systems of Care). All are charged with the responsibility of helping caregivers navigate their way through a complex and at times confusing service delivery system. Acting as "service brokers," Care Coordinators help parents identify their child's needs, choose among available service providers, develop and monitor treatment plans and connect the family to more permanent natural support systems. The goal of care coordination is to keep children at home and in their communities through collaborative involvement of a variety of service systems (mental health, school, juvenile justice, DCF). The majority of children seen by the Community Collaboratives are not DCF involved.

A recent, in-depth analysis of the children receiving care coordination indicates that some remain in this service well beyond the designated 6-month time period. (the average length of stay for the eleven providers who offer this service range from a high of 478 days to a low of 122 days). This finding may be the result of provider failure to report discharges in timely fashion, exacerbated by an inability to keep track of those cases for which no identifying information was provided. Alternatively, the needs and challenges within the families served may require longer lengths of stay before the caregiver feels empowered and sufficiently familiar with available services to coordinate care for their children independent of the care coordinator. It is important to note that length of stay for this service varies significantly across providers. Dialogue with Care Coordination agencies will undoubtedly help to further articulate the reasons behind this finding and will serve to direct Departmental action around additional training and technical assistance for care coordinators or perhaps, a redesign of the service model.

Additional data is now available on a quarterly basis for the children discharged from Care Coordination. Of the 130 children discharged during the course of this reporting period, 81 were boys and 49 were girls. 83 of the children served ranged in ages 5 through 13, while 43 were over 13 years of age. Approximately 60% of the children served had no DCF involvement, while 40% were involved with the Department in some fashion, including the Voluntary Services and Families with Service Needs programs. Referrals to care coordination came from a variety of sources including family, DCF, schools, and hospitals, with no one referral source being more prominent than the others. Similar to last quarter's report, the most frequent presenting problems for the children and youth referred for crisis intervention were depression and suicidal ideation. The next most frequent precipitant for calls to the mobile crisis units were on behalf of children who were exhibiting a cluster of disruptive, aggressive behaviors. On average, each child involved with Care Coordination received five different services with Family Advocacy, and out patient services being the most frequently utilized services.

Crisis Stabilization Units:

Crisis Stabilization Units were developed to assist youngsters in crisis who need extensive evaluation and support but who do not meet criteria for psychiatric hospitalization. The two programs, one located on the UCONN Health Care Center campus (operated in collaboration with Wheeler Clinic) and one on the campus of the Children's Center in Hamden, opened in June 2003 and to date, have collectively served **over 250 children** within their 8 bed programs. While the programs are designed to be short term in nature (15 days) children often remain longer due to lack of alternative living arrangements and/or lack of immediate outpatient services. During this quarter,

the two Crisis Stabilization programs report that approximately 12 of the 44 children discharged remained beyond the 15-day limit. This is a notable improvement from previous reporting periods and is most likely impacted by the high number of children who had parent involvement during the course of their stay. The average length of stay was between 15 and 30 days.

During this reporting period, **51** children were served within both programs: 23 boys and 28 girls. The children served ranged in age from 7 to 16 with the majority clustering between ages 13 and 15. Family members for 40 of the children served, participated in treatment services that included family therapy, phone contact, visits, etc. The majority of referrals to Crisis Stabilization came from the Mobile Crisis Teams, although some children were admitted directly through local DCF offices and community providers. The most common presenting problems demonstrated by the children admitted to service continue to be depression and suicidal ideation. The next most common cause for admission to the program was oppositional and defiant behavior coupled with aggression. Discharge plans from the units were varied, with the majority of children returning home with community based treatment plans in place. Of the 44 children discharged from care this quarter, 30 returned home, 5 went to foster homes, 5 were hospitalized ,2 were placed in residential facilities, and 2 were placed in shelters.

Anecdotal information from the programs indicates an increase in children admitted who are involved in the juvenile justice system and on probation. Conflicts with parents resulting in verbal and physical aggression account for many of the admissions. Almost three quarters of the children admitted to the crisis stabilization units were receiving psychiatric care prior to admission and were on medications. All required on-going psychiatric follow-up and additional treatment post discharge. Discharge delays this quarter tended to impact DCF involved children who were without family resources and for whom alternative living arrangement needed to be made.

Intensive Home-Based Services:

DCF continues to fund a statewide network of intensive home-based services. Teams of mental health professionals and support staff work closely with targeted children and their families to provide intensive treatment and rehabilitative services in the child's home. Using best practice and evidenced based models, these teams are often employed to assist families when a child is at risk for psychiatric hospitalization or residential care. These services are also supported by dollars dedicated for the treatment of non-DCF involved children through the Community Mental Health Strategy Board.

Models currently being utilized include Functional Family Therapy (FFT), Multi-Dimensional Family Therapy (MDFT), and Intensive In-Home Child and Adolescent Psychiatric Services (IICAPS).

IICAPS is currently operating under 15 contracts with various private providers (24 treatment teams) and approximately 200 families are served at any given time using this model. Four additional contracts are held with providers who offer MDFT (approximately 40 additional families). There is one service contract currently in place for FFT to serve 6-8 families at any given time.

Administrative Overview and Summary of Progress:

The Department of Social Services and the Department of Children and Families have committed to a statewide fiscal and programmatic reform of the publicly funded behavioral health service system for children and families. Through the employ of an Administrative Services Organization, both Departments anticipate developing a common administrative infrastructure that will enhance care by improving access to behavioral health services, coordinating between and across various levels of care and service types, and monitoring quality of care from the perspective of the consumer and the provider.

What is an Administrative Services Organization?

An Administrative Services Organization is a state contracted entity that will help DCF and DSS develop a common administrative infrastructure to enhance behavioral health care by improving access to care, coordination of care, and quality of care. Through the services of one contracted organization that reports directly to DSS and DCF, publicly funded behavioral health benefits from the Medicaid program and from DCF grants and contracts will be organized and monitored in a coordinated and integrated fashion.

What will the ASO do?

The ASO will authorize admissions to various levels of care, track the care of individual children and groups of children across services, identify and assist children and families for whom existing services do not appear to be working, help consumers and others identify all available resources, and connect children and families to crisis services. In addition, through the development of a data warehouse, the ASO will be able to provide each department with an extensive array of reports regarding the quality of services being provided, service gaps and systems problems. Unlike the existing managed care companies, the ASO will not be at financial risk and the clinical protocols and rates will be determined by both Departments with input from parents, consumers, and providers, making it a more transparent and collaborative model.

When will the ASO be operational?

The Request for Proposal for the Administrative Services Organization was released on September 26, 2004 and proposals were due on October 29, 2004. A team of reviewers that included staff members from DSS and DCF, a children's mental health advocate and two parents of children with mental health needs reviewed each of four proposals that were received. On December (date?) Value Options was notified of their award to negotiate a contract for the ASO.

Over the next few months, DSS and DCF will be working closely with legislators, advocates, parents and providers to obtain input. The Behavioral Health Oversight Committee will begin to meet under the leadership of Senator Christopher Murphy and Mr. Jeff Walter from Rushford Center. The purpose of the group has been re-defined to provide advice and consultation to DCF and DSS as plans for implementation and operation of the ASO become finalized. The group, comprised of providers, consumers and advocates will meet monthly and will help guide the implementation process.

It is anticipated that contract negotiations will occur during the early months of 2005 with full implementation to occur by October 1, 2005.